IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE

GAYNELL GRIER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	**No. 79-3107**
M.D. GOETZ, JR., Commissioner, Tennessee Department of Finance and Administration, *et al.*,	)	**Judge Nixon** **Magistrate Judge Knowles**
	)	
Defendants.	)	

DEFENDANTS' MOTION TO MODIFY AND/OR CLARIFY THE CONSENT DECREE

Pursuant to FED. R. CIV. P. 60(b), Defendants respectfully move for an order modifying and/or clarifying the Revised Consent Decree (Modified) (Doc. 908) to eliminate a number of restrictions extending beyond the requirements of federal law and to bring Tennessee's Medicaid program into line with those of other states. Specifically, Defendants respectfully move for an order providing that, notwithstanding anything to the contrary in the Revised Consent Decree (Modified) or any other order of this Court, the State (including any contractor acting as an agent of the State) (hereinafter the "State") may implement any of the following reforms to TennCare:

a. The State may implement all reforms approved by the Centers for Medicare and Medicaid Services ("CMS"), including but not limited to those approved in the letters to the State dated March 24, 2005, and June 8, 2005.

b. The State may require prior authorization by the TennCare Bureau as a condition of coverage for any drug or drug class so designated by the State, and the State may deny any

claim for reimbursement for a drug for which prior authorization is required but has not been obtained.

c. The State may implement a five prescription per month limitation pursuant to which at least three prescriptions must be generic, and any branded prescriptions are subject to a Preferred Drug List/formulary pursuant to which non-preferred prescriptions will require prior authorization by the TennCare Bureau as a condition of coverage.

d. When a request for prior authorization for coverage of a drug is denied, the Pharmacy Benefit Manager ("PBM"), on behalf of the State, will issue a notice informing the enrollee of the basis for the denial at the time the request is denied, which may be after the service has been denied by a provider. If the enrollee appeals the denial of prior authorization or coverage, the State will have no obligation to pay for the service during the pendency of any appeal. With respect to pharmacy coverage determinations, the state action from which an appeal may be taken is the State's denial of requested prior authorization. Where no prior authorization has been sought for a drug requiring such authorization in order to be treated as a covered service (and therefore no prior authorization request has been denied), there will be no state action from which a valid appeal can be taken. The State may dismiss without a hearing any appeal of a denial of prior authorization that does not raise a valid factual disputed issue.

e. After consultation with a Pharmacy and Therapeutics Committee established pursuant to Section 1927(d)(4)(A) of the Social Security Act, the TennCare Bureau may make all final decisions concerning the content of the formulary and the designation of drugs available to enrollees as covered services without prior authorization.

f. The State may categorically exclude coverage for any over-the-counter drug.

g. The State may refuse to dispense (or to reimburse a pharmacist who dispenses) a prescribed drug (or an interim supply thereof) for which prior authorization is a prerequisite to prescription as a covered service and has not been obtained, except that the State will reimburse for a 72 hour interim supply in an emergency situation. An emergency situation is a situation that, in the judgment of the dispensing pharmacist, involves an immediate threat of severe adverse consequences to the enrollee, or the continuation of immediate and severe adverse consequences to the enrollee, if an outpatient drug is not dispensed when a prescription is submitted. Paragraph C(14)(e) of the Revised Consent Decree (Modified) (providing that the three day period will revert to 14 days on January 1, 2006) shall be deleted.

h. When the State imposes benefit limits capping the number of in-patient hospital days per year, physician services per year, outpatient facility services per year, laboratory and x-ray services per year, inpatient and outpatient substance abuse services over the course of the enrollee's lifetime, and/or prescriptions per month that will be covered by TennCare, the State may deny any claim for services or reimbursement for services whenever such service would exceed a benefit limit imposed by the State. When a claim for service or reimbursement is denied by the State or a managed care contractor ("MCC") because the enrollee has reached the benefit limit, the State will issue a notice informing the enrollee of the basis for the denial at the time the claim is denied (which may be after the service has been denied by a provider). The State need not provide notice when an enrollee is approaching or reaches a benefit limit. A provider's refusal to render a requested service because the enrollee has reached a benefit limit does not, on its own, constitute action by the State, and the State need not provide notice in those circumstances. If the enrollee appeals the denial of coverage, the State may refuse to pay for the service during the pendency of any appeal from the denial. The State may dismiss without a

hearing any appeal of a denial based upon a benefit limit that does not raise a valid factual dispute concerning whether the benefit limit had, in fact, been exceeded, or whether the enrollee was in fact subject to the benefit limit (assuming that such a ground has not been waived pursuant to paragraph j, *infra*).

i. The State may impose and/or increase the co-pays charged for any TennCare service, and the State may deny any claim for services for which the co-pay has not been paid. When a claim for service is denied by reason of a failure to pay the co-pay, the State may refuse to pay for the service during the pendency of any appeal from the denial. The State may dismiss without hearing any appeal of a denial for refusal to pay the co-pay that does not raise a valid factual dispute concerning whether the co-pay had, in fact, been paid or was not required. A provider's refusal to provide a requested service because the enrollee did not pay the co-pay does not constitute action by the State, and the State need not provide notice in those circumstances.

j. Upon implementation of any benefit reforms to the TennCare program, if the State provides notice to all enrollees that complies with federal requirements and the terms of the TennCare waiver and the State provides enrollees an opportunity for a hearing on any valid factual dispute regarding the application of the benefit reform to them (i.e., issues related to their eligibility category), then the State may refuse to consider, as a ground for an appeal of a service denial, challenges to an enrollee's eligibility category that they had the opportunity to raise previously.

k. The State may dismiss an appeal without providing a hearing when the enrollee never requested the item or service sought in the appeal from the MCC in the first instance or when the item or service sought has not been ordered or prescribed by a provider.

l. The State may rely upon all relevant information, not just the enrollees' medical records, in determining TennCare coverage of medical services and in considering and deciding medical appeals. Paragraph C(7) of the Revised Consent Decree (Modified) shall be deleted.

m. The State may implement a screening process to identify appeals that are not based upon a valid factual dispute (i.e., an individualized dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage of the service sought in the appeal), and dismiss such appeals without providing a hearing.

n. The State may place the burden of proof in all medical appeals upon the enrollee.

o. The State may appeal a medical appeal decision rendered at any stage of the process in favor of the enrollee, consistent with the Tennessee Uniform Administrative Procedures Act.

p. The State may revise the time limitations for filing and resolving medical appeals to conform with federal requirements, and the State may limit expedited appeals to circumstances as required by federal regulations.

q. The State may remedy any defect in a required notice or statement of reasons or legal authorities by providing a corrected notice or statement, provided that, when the State does so, the time permitted for an enrollee's response will be restarted. Paragraph C(1)(f) and C(1)(g) of the Revised Consent Decree (Modified) shall be deleted.

r. The State may evaluate all claims for TennCare services in accordance with the definition of medical necessity established by State law (including regulations issued pursuant to the promulgating statute), and the State may deny any claim for a service that the State has concluded is not medically necessary as that term is defined under State law. The State, not a

provider, will have the ultimate authority to determine whether a medical item or service that has been prescribed by a provider is medically necessary.

s. The State may implement a reasonable set of geographic and/or clinical hardship criteria to determine when enrollees will be allowed to transfer between MCCs outside of defined open enrollment periods.

t. The Consent Decree in this case, as revised, will terminate at the end of the current term of the State's TennCare waiver unless the Court determines that there are ongoing or imminently likely violations of federal law, in which case the decree will be limited to those provisions of the decree as revised that are necessary to remedy any such violations of federal law.

In support of this motion, Defendants submit the accompanying Memorandum, and will present evidence at the hearing commencing on June 29, 2005.

June 15, 2005

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served on the following by electronic mail and by U.S. Mail, postage pre-paid, on this 15th day of June, 2005:

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